

Michigan Department of Community Health
Board of Physical Therapy
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

PHYSICAL THERAPY RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Physical Therapy. Questions regarding your application can be directed to the Michigan Board of Physical Therapy at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, the applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send original application, with the proper fee, to the Board of Physical Therapy. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
 - a. If your Physical Therapy license expired within the last 3 years, complete the relicensure application and return it with the appropriate fee.
 - b. If your Physical Therapy license expired more than 3 years ago and a permanent physical therapy license or registration is currently held in one or more states, each state must submit verification of licensure directly to the Board office. You must also submit the relicensure application and fee.
 - c. If your Physical Therapy license expired more than 3 years ago but a permanent physical therapy license or registration is not currently held in another state, an applicant must take and pass the National Physical Therapy Examination (NPTE).
 1. You must submit your application for relicensure with the appropriate fee.
 2. All applicants for the NPTE must apply on-line. The on-line application and payment process for the NPTE is available at www.fsbpt.net/pt. See the *NPTE Candidate Handbook* for complete instructions or check the website at www.fsbpt.org.
 3. You will be sent an Authorization to Test from the NPTE after you have applied for the NPTE and have been made eligible for the exam by the Michigan Board of Physical Therapy. The Authorization to Test will include a telephone number for you to call to schedule your examination at a Prometric Testing Center. Once you have received your Authorization to Test, you must sit for the examination within 60 days. You will be required to submit a testing fee to Prometric Testing Center before taking the examination.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Physical Therapy in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Physical Therapy in writing to request a refund.
3. ***If you require special testing accommodations because of a disability, you must submit a letter indicating the accommodation requested and your disability. You must also submit a letter verifying the disability and the requested accommodation from a licensed health provider capable of making the diagnosis. In addition, please include a letter or other documentation from school personnel verifying the accommodations made during your education. These documents should be included when you submit your license application and preferably prior to that date. The information should be sent to: Department of Community Health, ADA/Applications, Bureau of Health Professions, P.O. Box 30670, Lansing, MI 48909.***

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

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DCH/LPT-400 (03/04)

Page 1 of 2

APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING: <input type="checkbox"/> Relicensure Fee: \$100.00 71-5501-06 Your check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.			Board Use Only					
			License Number:					
			Date of Licensure:					
First Name			Middle Name			Last Name		
U.S. Social Security Number			Date of Birth			Michigan Permanent I.D. Number and Expiration Date		
Street Address								
City			State			ZIP Code		
Daytime Telephone Number			All Previous Names and/or Birth Name Used (if applicable)					
Has your Michigan physical therapy license been lapsed more than three years? <input type="checkbox"/> Yes <input type="checkbox"/> No								

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?

☐ Yes ☐ No

List each state(s) in which you hold or have ever held a permanent physical therapy license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)**

State	License Number	Date of Issue	How was it obtained (Endorsement or examination)

If your license expired **WITHIN THE LAST 3 YEARS**, complete this form and return it along with the appropriate fee.

If your license expired **MORE THAN 3 YEARS AGO**, please check the appropriate box below and follow the instructions given:

☐ 1. I do hold a current license in the following state:

☐ 2. I do not hold a current license in another U.S. Jurisdiction and, therefore, must take and pass the National Physical Therapy Examination. (Applicants should contact the FSBPT at www.fsbpt.org for information; on-line registration is at www.fsbpt.net/pt.)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant

Date

Michigan Department of Community Health

Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
	<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary	
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board